Authorization For The Use and Disclosure of Individually Identifiable Health Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive my be re-disclosed and no longer protected by federal privacy regulations.

1. Persons/organizations authorized to use or disclose the information:
   Office of Dr. Amy Mok, OD. Optic Dimension, Pllc.

2. Persons/organizations authorized to receive the information: **Lenscrafters**

3. Specific description of information that may be used/disclosed:
   My name, address, telephone number, email address and next appointment date(s) and time(s).

4. As part of our recall program, the information might be used/disclosed for the following purposes: **For the purpose of providing LensCrafters coupons and service and product information either from this office or directly from LensCrafters; and to compare contact lists with LensCrafters to help avoid duplicate contacts related to eye exam scheduling within similar time frames.**

5. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment or eligibility for benefits unless allowed by law.

6. The organization authorized to use/disclose the information will receive compensation for doing so. **Yes** _____ **No** __X___

7. I understand that I may inspect or copy the information used or disclosed.

8. I understand that I may revoke this authorization at any time by notifying the person/organization providing the information in writing, except to the extent that:
   a) action has been taken in reliance on this authorization; or
   b) if this authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

9. This authorization expires four years from the date of my signature.

_____ _____
Signature of Patient/Patient's Representative **Date**

_____ _____
Printed name of Patient/Patient's Representative **Relationship to Patient or Representative's authority to act for Patient**

Acceptance of Optic Dimension, Pllc HIPAA and Payment Policies

Most of our patients feel that our exams are fair value. We will give individual, careful attention to you, but because of many factors we may have to adjust your prescription. The doctor will gladly see you for Rx changes at **NO CHARGE** as long as you return **WITHIN 60 DAYS** of your **ORIGINAL** exam date. As with other doctors that you see, kindly understand that one fee is not for unlimited care and that fees and copays are due at the time of service and are not refundable. Problems arising after the initial visit (except for 60 day changes) will have additional fees. All contact lens evaluations include **60 DAYS** of related follow up. After 60 days, a $20 fee per visit will be charged. Any additional testing will incur additional costs.

I understand that my vision insurance may pay less than the actual bill for services and that I will be responsible for payment of additional or non-covered procedures for myself and my dependents. In the event that my insurance company refuses payment, for any reason, I agree to be responsible for payment of all services rendered on my behalf and my dependents. Service charges of 1.5% per month will be added on all balances over 60 days past due. If it becomes necessary to collect fees through litigation or a collection agency, I agree to pay all collection fees, court costs, deposition fees and attorney's fees incurred by Optic Dimension, Pllc. *I understand that there is a $25 fee for all returned checks.*

Our office follows national HIPAA requirements to maintain your privacy of medical and personal information. Some information from your exam needs to be shared with optical and other medical providers to continue your care. By signing below, you acknowledge having read or been given our offices "Notification of Privacy Practices' and give us permission to release your findings to other health care providers in the event of referral or prescription release. Thank you for reviewing and understanding the above policies.
I have read and accept the above policies.

_____ _____
Signature of Patient/Patient's Representative **Date**

_____ _____
Printed name of Patient/Patient's Representative **Relationship to Patient**

_____ _____
Update Signature **Date**

Although not a mandatory procedure, dilation is recommended to provide a more thorough evaluation of the internal health of the eyes (included in your exam fee). With dilation, temporary sensitivity to sunlight and blurred vision are expected to last 4-6 hours, sometimes causing driving difficulties and returning to work or school may be difficult.

Alternately, for $35 the Optomap can capture a digital image of your retina without the effects of being dilated. Dilation may still be necessary if anything unusual appears on the image.

◯ I would like to have the Optomap performed for $35
◯ I would like the dilation to be performed
◯ I do not want dilation to be performed

_____ _____
Signature of Patient/Patient's Representative **Date**

_____ _____
Update Signature **Date**